

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

78-14

CERTIFICATE OF DEATH

Reg. Dist. No.

07809

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Ellicott City</u>		OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>90</u> <u>Shaffer's Convalescent Retreat, Montgomery Road</u>		<u>2716 N. Howard Street</u> ✓	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print)	(First) (Middle) (Last)	OF DEATH: <u>AUGUST 14, 1955</u>	
<u>LOUISE BENNETT</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>female</u>	<u>white</u>	<u>Single</u>	<u>Feb. 28, 1856</u>
9. AGE last birthday		10. CITIZEN OF WHAT COUNTRY?	
<u>99</u> yrs.		<u>U. S. A.</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Baltimore, Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Patrick H. Bennett</u>		<u>Sophia Farnham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
---		---	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Bessie Herchenhahn, 2716 N. Howard</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		INTERVAL BETWEEN ONSET AND DEATH	
		<u>?</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan. 13, 1955</u> , to <u>Aug 14, 1955</u> , that I last saw the deceased alive on <u>Aug 13, 1955</u> , and that death occurred at <u>7 A</u> M. from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS <u>10374. Cedar St Baltimore 8/15/55</u>	
DATE SIGNED <u>8/16/55</u>		M. D. <u>10374. Cedar St Baltimore 8/15/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>burial</u>		<u>8/16/55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Loudon Park Cemetery</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<u>8/16/55</u>		<u>Wm Cook, Inc., 1217 St. Paul Street</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

07810

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

73 15

1. PLACE OF DEATH - COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland		COUNTY Prince George	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Rt. #2 Woodbine		LENGTH OF STAY (in this place) 4 months		CITY (If outside corporate limits, write RURAL and give nearest town) Berwyn		16 X - 2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt #2 Woodbine				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (First) (Middle) (Last) Margaret Jane Bewley		4. DATE OF DEATH (Month) (Day) (Year) August 3, 1955		5. SEX Female		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH 6/12/1881		9. AGE last birthday 74 yrs.		If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Doaktown, N.B. Canada		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel D. Betts		14. MOTHER'S MAIDEN NAME Hester Mc Kinnon		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk -		16. SOCIAL SECURITY NO. Unk -	
17. INFORMANT AND ADDRESS Mrs. John D. Bewley, Rt 2 Woodbine, Md		18. MEDICAL CERTIFICATION		19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.1 Immediate cause (a) Chronic Myocarditis				Antecedent cause(s) (b) Arterio Sclerosis		3 mro years	
(c)				11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 7/30		19b. MAJOR FINDINGS OF OPERATION —		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) —		PLACE (Home, farm, factory, street, OF office bldg., etc.) —		(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY —		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? —			
22. I hereby certify that I attended the deceased from 6/25 , 19 55 , to 7/30 , 19 55 , that I last saw the deceased alive on 7/30 , 19 55 , and that death occurred at 9:30 a.m. , from the causes and on the date stated above.							
SIGNATURE [Signature]		(Degree or title) M.D.		ADDRESS Sandy Sp...		DATE SIGNED 8/3/55	
23. BURIAL CREMATION REMOVAL (Specify) Reinterment		DATE THEREOF 8-3-55		NAME OF CEMETERY OR CREMATORY Hyattsville, Md		(State)	
DATE REC'D BY LOCAL REG. Sept. 6, 1955		REGISTRAR'S SIGNATURE E. Pearl Mercier		24. FUNERAL DIRECTOR Joseph Funeral Home - Hyattsville, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 7 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

07811

2411 N. Charles Street, Baltimore

7395

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH- COUNTRY <u>Howard</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <input checked="" type="checkbox"/> TOWN <u>Ellicott City</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ellicott City</u>		<input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Columbia Road</u>				STREET ADDRESS <u>Columbia Road</u>		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First) <u>BARBARA</u>		(Middle) <u>LORETTA</u>		(Last) <u>BIANEY</u>	
4. DATE OF DEATH <u>8-10-55</u>		(Month)		(Day)		(Year) <u>19</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>10-7-1868</u>	
9. AGE last birthday <u>86</u> yrs.		If under 1 year Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Catonsville, Md</u>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>George Schatz</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Betzold</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Isabelle Barger, Ellicott City, Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>420.0</u> <u>acute cardiac failure</u>		<u>12 hrs</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<u>20 years</u>
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/29, 1946, to 8/9, 1955, that I last saw the deceased
alive on 8/9, 1955, and that death occurred at 12:10 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>8-13-55</u>	NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	LOCATION (City, town, or county) <u>Baltimore, Md</u>	(State)
DATE REC'D BY LOCAL REG. <u>Aug 10, 1955</u>	REGISTRAR'S SIGNATURE <u>John B. Loughman</u>	24. FUNERAL DIRECTOR <u>F.C. Higinbotham</u>	ADDRESS <u>Ellicott City, Md.</u>	

P. B. E. G.

MARGIN RESERVED FOR BINDING

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RECEIVED

AUG 12 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Items 7, 13, 14, 24 Film 185 8-15-55 at Item 14 Film 185 8-17-55 at 07812

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 191

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Howard		MARYLAND		STATE Tenn		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN Ellicott City (rural)				TOWN La Follette 79X-3			
HOSPITAL OR INSTITUTION OR Rt. 103 500 feet north of STREET ADDRESS Meadowridge Road.				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
John Franklin Comer RA 14513984				Aug. 1, 1955 19			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday: yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Single	8-31-35	19	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): U.S. Army		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Campbell Co., Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Henry Comer				14. MOTHER'S MAIDEN NAME: Josephine Ivey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Martin Funeral Home, Lake City, Tenn.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
823X Immediate cause (a) 2nd and 3rd degree burns upper half of body & head DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						Instant	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Fracture of left femur							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Highway		21c. (City or town) (County) (State)			
Ellicott City Howard Md							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 8-1-55 9.58 P M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Car left road struck utility pole and burned			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE George E. Burdorf		Ellicott City, Md		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8-1-55	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 8-5-55		NAME OF CEMETERY OR CREMATORY ---		LOCATION (City, town, or county) (State) LaFollette, Tenn.	
DATE REC'D BY LOCAL REG. Aug. 4, 1955		REGISTRAR'S SIGNATURE John Loughran		24. FUNERAL DIRECTOR Martin Funeral Home, Lake City, Tenn.		ADDRESS	

RECEIVED

AUG 5 1955

BUREAU V. S.

7813

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
<u>X</u> TOWN <u>Ellicott City</u>		<u>3</u> days		TOWN <u>Baltimore 29</u> <u>03X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Taylor Manor Hospital</u>				STREET ADDRESS (If rural give location) <u>112 Malbrook Road</u> ✓			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Ferdinand</u>		(Middle) <u>JOHN</u>		(Last) <u>Deichmiller</u>	
4. DATE OF DEATH:		(Month) <u>August</u>		(Day) <u>22</u>		(Year) <u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Dec. 28, 1892</u>	<u>62</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Optical Tech. Optical</u>		<u>Optical</u>		<u>Baltimore, Md.</u>		<u>U.S.</u>	
13. FATHER'S NAME: <u>John Deichmiller</u>				14. MOTHER'S MAIDEN NAME: <u>Katherine Engelhaupt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>213-03-0970</u>		17. INFORMANT & ADDRESS: <u>Lillian G. Deichmiller 112 Malbrook Rd</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>				<u>45 min.</u>			
ANTECEDENT CAUSE (B) <u>Arteriosclerotic Cardiovascular dis.</u>				<u>? sev. Yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Agitated depression</u>				<u>2 mos.</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
2. I hereby certify that I attended the deceased from <u>Aug. 20 1955</u> to <u>Aug. 22, 1955</u> , that I last saw the deceased alive on <u>Aug. 22, 1955</u> and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Leonard M. Rothstein, MD</u>		ADDRESS <u>M.D. Taylor Manor Hospital</u>		DATE SIGNED <u>Aug 22, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 25-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Landon Park Ave</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
DATE REG'D BY LOCAL REGISTRAR <u>8/23/55</u>		REGISTRAR'S SIGNATURE <u>U. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>John F. Tenzel</u>		ADDRESS <u>5311 Edmondson Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TO: DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION
FROM: [Illegible]
SUBJECT: [Illegible]
[Illegible text follows]

[Illegible text follows]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

73 19 MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles Street, Baltimore
CERTIFICATE OF DEATH

07815

Reg. Dist. No. 191

1. PLACE OF DEATH- COUNTY Howard MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Ellicott City		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Highland Manor Nursing Home		STREET ADDRESS (If rural, give location) 2838 Edmondson Avenue	
3. NAME OF DECEASED (Type or Print) James T. Gaskins		4. DATE OF DEATH August 24 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH Jan. 16, 1864 91 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Donut Corp. of Amer Northumberland, Pa.	
13. FATHER'S NAME William Gaskins		14. MOTHER'S MAIDEN NAME Rebecca M. MacGregor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT AND ADDRESS Damon S. Gaskins 2838 Edmondson Ave	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

610X Immediate cause (a) Uremic Coma	INTERVAL BETWEEN ONSET AND DEATH 1 week
Antecedent cause(s) (b) Bilateral Hydrocephalus	?
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Benign Paroxysmal Hypertension	3-5 yrs.

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **8/17**, 19**55**, to **8/24**, 19**55**, that I last saw the deceased alive on **8/17**, 19**55**, and that death occurred at **1.35 A.M.**, from the causes and on the date stated above.

SIGNATURE

Chas J Miller MD

ADDRESS

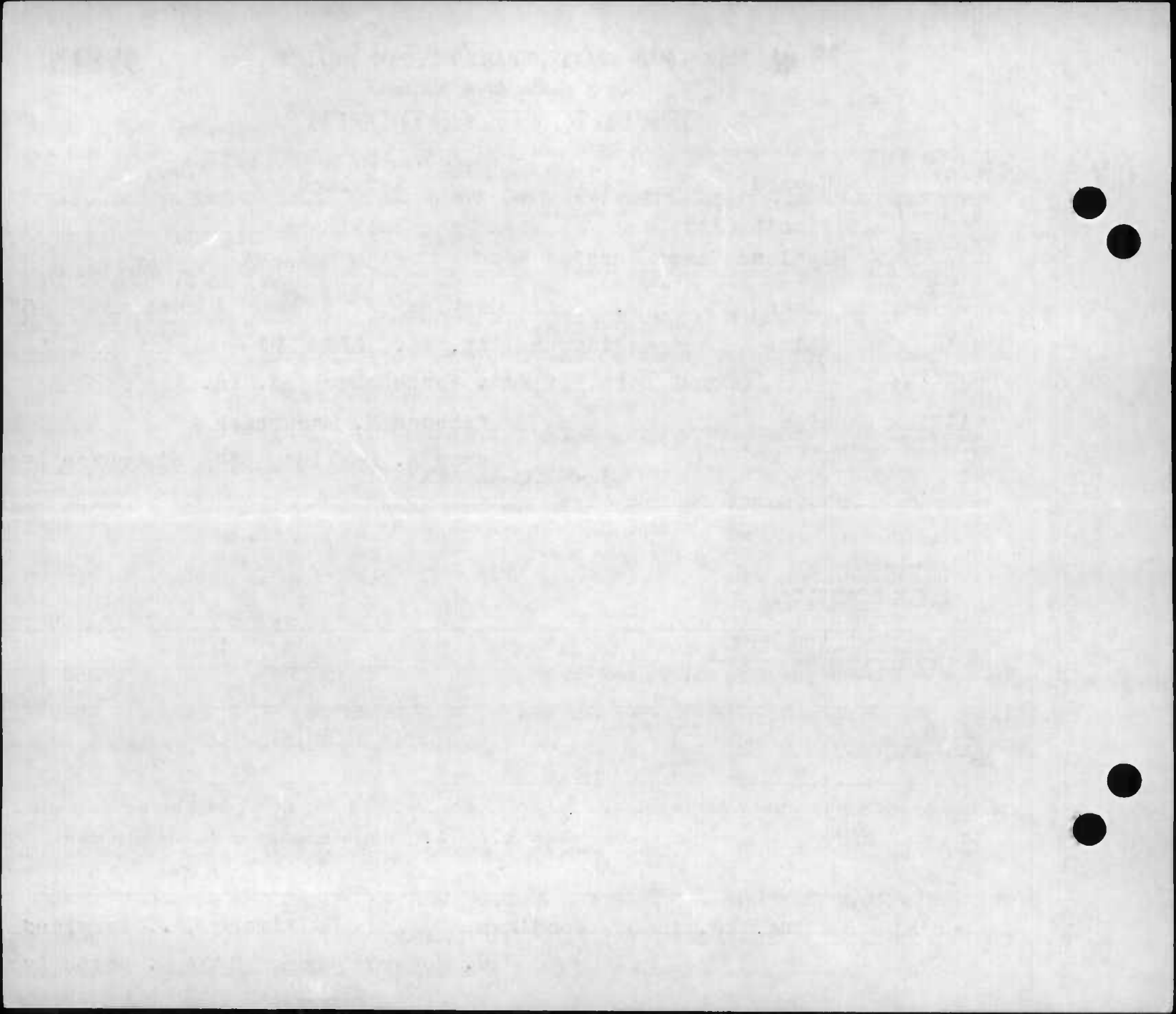
5226 BOLD. NAT. Pike

DATE SIGNED

8/25/55

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Aug. 26, 1955	NAME OF CEMETERY OR CREMATORY Woodlawn	LOCATION (City, town, or county) (State) Baltimore Co., Maryland
DATE REC'D BY LOCAL REG. 25-55	REGISTRAR'S SIGNATURE <i>[Signature]</i>	24. FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave	

Norace F. Dunbar



7319

MARYLAND STATE DEPARTMENT OF HEALTH

07816

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH COUNTY Howard MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Howard	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Ellicott City		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Ellicott City X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 05 Old Frederick Road		STREET ADDRESS (If rural, give location) Old Frederick Road	
3. NAME OF DECEASED (Type or Print)	(First) MINOTIA (Middle)	(Last) HARBIN	4. DATE OF DEATH (Month) August (Day) 24 , (Year) 1955
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH October 5, 1967
9. AGE last birthday 87 yrs.		10. BIRTHPLACE (State or foreign country) Virginia	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		12. CITIZEN OF WHAT COUNTRY? None	
13. FATHER'S NAME George Cowan		14. MOTHER'S MAIDEN NAME Mary Cassel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS George Harbin, Ellicott City, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Arteriosclerotic Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH

2 years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **7/1**, 19**53**, to **8/24**, 19**55**, that I last saw the deceasedalive on **8/24**, 19**55**, and that death occurred at **9:20** p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 8-27-55	NAME OF CEMETERY OR CREMATORY Good Shepherd	LOCATION (City, town, or county) Ellicott City, Md	(State)
DATE REC'D BY LOCAL REG. Aug. 27, 1955	REGISTRAR'S SIGNATURE John B. Loughman	24. FUNERAL DIRECTOR F.C. Higinbotham	ADDRESS Ellicott City, Md.	

Per B.E. L.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 2 1955

BUREAU V. S.

MARYLAND

STATE DEPARTMENT OF HEALTH

7811

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH- COUNTY Howard MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Ellicott City		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Highland Nursing Home		STREET ADDRESS (If rural, give location) 1314 E. Belvedere Ave	
3. NAME OF DECEASED (First) Nora (Middle) C. (Last) Heath	4. DATE OF DEATH (Month) Aug (Day) 13 (Year) 1955		
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S	8. DATE OF BIRTH JAN. 9-1868
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edwin H. Heath		14. MOTHER'S MAIDEN NAME Sarah R.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Walter R. Heath 1314 E. Belvedere Ave.			

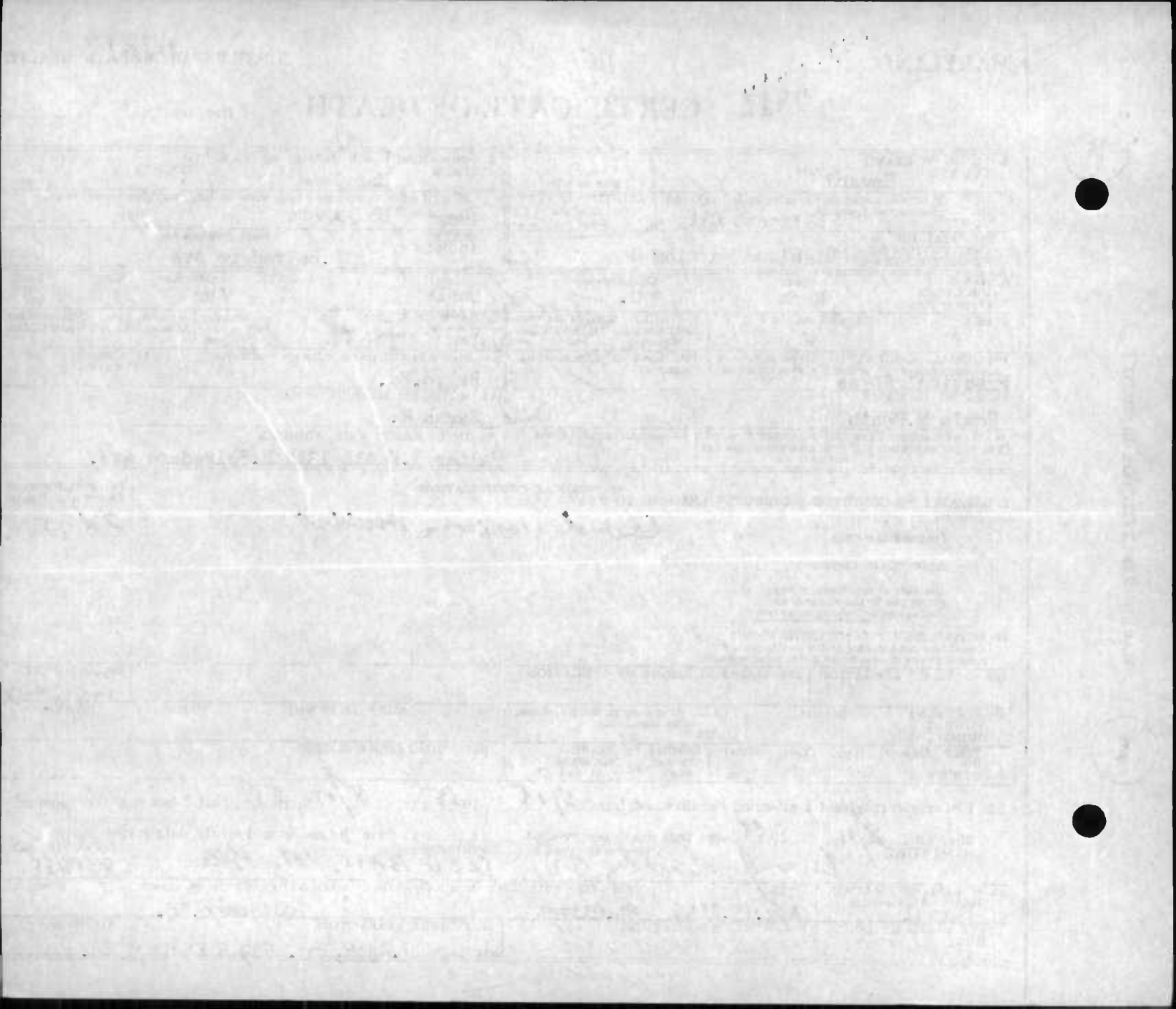
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
331X Immediate cause (a)..... Cerebral Vascular Accident			2 days
Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/15, 1955, to 8/13, 1955, that I last saw the deceased alive on 8/11, 1955, and that death occurred at 5226 BALR. HART. RD m., from the causes and on the date stated above.

SIGNATURE <u>Wm J. Miller</u>	DATE <u>Aug. 15, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>	DATE SIGNED <u>8/14/55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE REC'D BY LOCAL REG. <u>8-15-55</u>	REGISTRAR'S SIGNATURE <u>Wm J. Miller</u>	24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc.</u>	ADDRESS <u>530 5 Harford Rd.</u>

MARGIN RESERVED FOR BINDING



07819

MARYLAND

7812

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH COUNTY Howard MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Ellicott City		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Highland Manor Nursing Home		STREET ADDRESS (If rural, give location) 5312 Catalpha Road #14	
3. NAME OF DECEASED (Type or Print) Mrs. Susan E. Kerner		4. DATE OF DEATH (Month) August 30 (Day) 30 (Year) 55	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH July 10, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY at home	9. AGE last birthday 78 yrs.
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mr. James Thompson		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mrs. Gilbert Adelhardt, 6308 Marietta Ave.			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
416X Immediate cause (a) Cerebral Vasc. Accident		Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis, generalized Rheumatic Heart Disease	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (c)			
19a. DATE OF OPERATION			

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from....., 19....., to Aug 30, 1955, that I last saw the deceased alive on Aug 26, 1955, and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE Linas J. Miller (M.D.)		ADDRESS 5226 Balt. Not. Ave		DATE SIGNED 8/30/55
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Sept. 2, 1955	NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	LOCATION (City, town, or county) Baltimore, Maryland	
DATE REC'D BY LOCAL REG. - 8/31-53	REGISTRAR'S SIGNATURE J.W. Hedrick	24. FUNERAL DIRECTOR Leonard J. Ruck, 5305 Harford Road #14		ADDRESS

MARGIN RESERVED FOR BINDING

Church T.D.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <i>Joseph C. Kreeger</i>		2. DATE OF DEATH <i>Aug 13, 1955</i>	
3. PLACE OF DEATH: <i>Howard County</i> A. <i>Baltimore City, Maryland</i> Church St., Ellicott City, Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Highland Mann Nursing Home</i>		6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
7. STREET ADDRESS (If rural, give location) <i>Grand Hotel, Fayette Place St</i>		8. DATE OF BIRTH <i>6/3/87</i>	
9. LENGTH OF STAY IN BALTIMORE <i>60 yrs</i>		9. AGE (In years last birthday) <i>68</i>	
10. SEX <i>M</i>	11. COLOR OR RACE <i>W</i>	12. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Divorced</i>	13. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Handy man</i>		15. KIND OF BUSINESS OR INDUSTRY <i>Grandview Inn</i>	
16. FATHER'S NAME <i>Alexander Kreeger</i>		17. MOTHER'S MAIDEN NAME <i>Amelia Garrisa</i>	
18. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		19. SOCIAL SECURITY NO. <i>215-22-3179</i>	
20. INFORMANT <i>Joseph P. Kreeger</i>		21. ADDRESS <i>8105 Bayburn Road</i>	
22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Acute Myocardial Infarction</i>		23. CAUSE OF DEATH <i>Bothesda, Maryland</i>	
24. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Arteriosclerosis Heart Dis.</i>		25. INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>	
26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
27. DATE OF OPERATION <i>June 1, 1955</i>		28. MAJOR FINDINGS OF OPERATION	
29. TIME (Month) (Day) (Year) (Hour) OF INJURY		30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
31. HOW DID INJURY OCCUR?		32. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
33. I hereby certify that I attended the deceased from <i>June 1, 1955</i> to <i>Aug 13, 1955</i> , that I last saw the deceased alive on <i>Aug 11, 1955</i> , and that death occurred at <i>11 p.m.</i> , from the causes and on the date stated above.			
34. SIGNATURE <i>Wm J. Twilly</i>		35. ADDRESS <i>5226 BACF. MAR. PIKE</i>	
36. DATE <i>August 17, 1955</i>		37. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>	
38. LOCATION (City, town, or county) <i>Pikesville, Maryland</i>		39. STATE <i>Maryland</i>	
40. DATE RECEIVED BY LOCAL REGISTRAR		41. REGISTRAR'S SIGNATURE <i>Eleanor D. Pennington</i>	
42. FUNERAL DIRECTOR		43. ADDRESS	

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINTEXT UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7814 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Poplar Spring</u>	LENGTH OF STAY (in this place) <u>19 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Poplar Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 3, Mt. Airy, Md.</u>		STREET ADDRESS (If rural give location) <u>Route 3, Mt. Airy, Md.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Luigi</u> - <u>Lizi</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Aug. 27</u> 1955	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>June 4, 1898</u>
9. AGE last birthday <u>57</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>merchant</u>		12. KIND OF BUSINESS OR INDUSTRY: <u>Store</u>	
13. FATHER'S NAME: <u>Pasquale Lizi</u>		14. MOTHER'S MAIDEN NAME: <u>P.P.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>yes.</u>		16. SOCIAL SECURITY NO. <u>218-18-2523</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Mary C. Lizi, Route 3, Mt. Airy, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Acute Coronary Thrombosis</u>		<u>About 10 minutes</u>	
ANTECEDENT CAUSE (S) (B) <u>Coronary Arteriosclerosis</u>		<u>About 2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug.</u> , 1955, to <u>Aug.</u> , 1955, that I last saw the deceased alive on <u>July 1</u> , 1955, and that death occurred at <u>11:30</u> AM, from the causes and on the date stated above.			
SIGNATURE <u>W.B. Culwell</u>		ADDRESS <u>Mt. Airy, Md.</u> DATE SIGNED <u>August 27, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>8-30-1955</u>	
NAME OF CEMETERY <u>Pine Grove</u>		LOCATION (City, town, or county) (State) <u>Mt. Airy, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept. 6, 1955</u>		REGISTER'S SIGNATURE <u>E. Pearl Mancini</u>	
24. FUNERAL DIRECTOR <u>C. M. Waltz</u>		ADDRESS <u>Winfield, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 7 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07822

CERTIFICATE OF DEATH

Reg. Dist. No.....

7315
Howard

1. PLACE OF DEATH- COUNTY <u>Highland</u> <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>	
TOWN <u>Ellicott City</u>		TOWN <u>Balto</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highland Cemetery Home</u>		STREET ADDRESS (If rural, give location) <u>1718 N. Bradford St</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Anna M. Mason</u>		<u>Aug 31</u> <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 14 1889</u> <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. FATHER'S NAME <u>John B. Weisman</u>		12. CITIZEN OF WHAT COUNTRY? <u>Md</u>	
13. MOTHER'S MAIDEN NAME <u>Laura V. Everett</u>		14. BIRTHPLACE (State or foreign country) <u>Md</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mrs. W. Mason 1718 N. Bradford St</u>	
17. INFORMANT AND ADDRESS <u>Mrs. W. Mason 1718 N. Bradford St</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X
Immediate cause

(a)

Cerebral Vasc. Accident

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Cerebral Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/2, 1955, to 8/31, 1955, that I last saw the deceasedalive on 8/26, 1955, and that death occurred at 6:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial Sept 3 1955 Western Edmondson Ave

9-255 W. H. Redwood Leo G. Lusk 1701-03 N. Patterson Park Ave

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Handwritten text, possibly a signature or name, located in the upper left quadrant of the page.

Handwritten text, possibly a signature or name, located in the upper right quadrant of the page.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7816

07823

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 191

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Howard		MARYLAND		STATE D.C.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN Ellicott City				TOWN Washington 47X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		2 mile west of Rt. 1 on route #175		STREET ADDRESS (If rural, give location)			
				1416 14th Street NW ✓			
3. NAME OF DECEASED: (Type or Print)		(First) Ralph (Middle) Mc Kinney (Last)		4. DATE OF DEATH (Month) (Day) (Year)			
				Aug. 16 19 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday: yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Colored		May 15, 1914	41	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer		10b. KIND OF BUSINESS OR INDUSTRY: Paving Construction		11. BIRTHPLACE (State or foreign country): South Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Wesley Mc Kinney				14. MOTHER'S MAIDEN NAME: Hessie Watkins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: 242-12-8369		17. INFORMANT & ADDRESS: Osborne Mc Kinney, 1418 9th NW Washington, D.C.			
WW 2							
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
824X Immediate cause (a) Compound fracture of skull DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							Instant
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Multiple Fractures							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Highway		21c. (City or town) (County) (State)			
				Rt. #175 Ellicott City (rural Howard Md			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 8-16-55 10.38 AM		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fell from moving truck which ran over him.			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE George E. Bampton M.D.		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8-16-55	
		Ellicott City, Md.		M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): Removal		DATE THEREOF 8-17-55		NAME OF CEMETERY OR CREMATORY MEMU		LOCATION (City, town, or county) (State) Washington, D.C.	
DATE REC'D BY LOCAL REG. 8-17-55		REGISTRAR'S SIGNATURE John B. Loughran, Jr.		24. FUNERAL DIRECTOR Hall Bros. 621 Florida Ave. NW		ADDRESS Washington D.C.	
		B. E. L.					

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7846

Washington, D.C.

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BUREAU V. S.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07824

7817

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>HOWARD</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Howard</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> <u>Brookville</u> (Rural)				<u>Brookville</u> (rural) <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenwood</u>				STREET ADDRESS (If rural give location) <u>Glenwood</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>CHARLES J. PIPES Sr.</u>				<u>Aug. 15 19 55</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED , WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>June 20, 1985</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Farm Owner</u>		11. BIRTHPLACE (State or foreign country): <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <u>Hiram J. Pipes</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>220-30-6019</u>		17. INFORMANT & ADDRESS: <u>Nerva Pipes, Brookville, Md</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE							
(A) <u>Coronary Thrombosis, Atherosclerosis, generalized</u>						<u>2 years</u>	
ANTECEDENT CAUSE (S)							
(B) <u>Arteriosclerotic heart disease, longhypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>1952</u> , to <u>Aug</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>15 Aug</u> , 19 <u>55</u> , and that death occurred at <u>11:20 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Howard E Hall</u>				M. D. <u>Severnville, Md</u>		DATE SIGNED <u>15 Aug 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>AUG. 20, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>		LOCATION (City, town, or county) (State) <u>Alpha, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8-9-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>F.C. Higinbotham</u>		ADDRESS <u>Ellicott City, Md</u>	

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7318

07826

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 192

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Howard		MARYLAND		STATE Maryland COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
X TOWN Marriottsville				TOWN Baltimore 3V01-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1 mile east of Marriottsville on south branch Patapsco				STREET ADDRESS (If rural, give location) 708 S. Ponca St. ✓			
3. NAME OF DECEASED: (Type or Print)		(First) W A I N E		(Middle) VERNON		(Last) TEETS	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		4. DATE OF DEATH August 7, 1955 19	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		4. DATE OF DEATH August 7, 1955 19	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Body builder		10b. KIND OF BUSINESS OR INDUSTRY: automobile		8. DATE OF BIRTH: AUG 24, 1932		9. AGE last birthday: 23 yrs. 22 Months 22 Days	
11. BIRTHPLACE (State or foreign country): Kingwood, W. Va.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME: Teil Teets				14. MOTHER'S MAIDEN NAME: Evelyn Metting			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes (If Yes, give war or dates of service) W.W.11				16. SOCIAL SECURITY No.: 235-52-1594		17. INFORMANT & ADDRESS: Mrs Evelyn Teets, R.D.2. Kingwood, W. Va.	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<p>Immediate cause (a) Asphyxiation (drowning)</p> <p>Antecedent cause(s) (b) DUE TO</p> <p>Diseases or conditions, if any, giving rise to the above cause DUE TO</p> <p>stating underlying cause last (c)</p>				Instant	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) Patapsco River		21c. (City or town) (County) (State) Marriottsville Howard Md	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 8-7-1955 1.15 PM		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Drowning, Swimming Patapsco River	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE Charles S. Whitaker, M.D.		CLARKSVILLE, Md.		M. D. CHIEF MEDICAL EXAMINER 8-7-55	
23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL		DATE THEREOF 8-10-55		NAME OF CEMETERY OR CREMATORY MT. MORIAM	
LOCATION (City, town, or county) (State) KINGWOOD W. Va.		24. FUNERAL DIRECTOR ALICE W. HERT		ADDRESS F. H. HIGHTHOM ELLICOTT CITY Md.	
DATE REC'D BY LOCAL REG. 8-9-55		REGISTRAR'S SIGNATURE			

07223

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BUREAU V. 31

1955

RECEIVED

7319

CERTIFICATE OF DEATH

Reg. Dist. No.

190

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY HOWARD	MARYLAND	STATE MARYLAND	COUNTY HOWARD
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN ELKRIDGE	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN ELKRIDGE	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5800 OLD WASHINGTON BLVD.		STREET ADDRESS (If rural give location) 5800 OLD WASHINGTON BLVD.	
3. NAME OF DECEASED: (First) (Middle) (Last) GRACE AGNEW TOOMEY		4. DATE (Month) (Day) (Year) OF DEATH: AUGUST 3, 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: February 19, 1881
9. AGE last birthday 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Thomas A. Agnew		14. MOTHER'S MAIDEN NAME: Mary Ann Martin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: Mr. Charles E. Toomey, Jr., 5611 Washington Blvd			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Instant.
IMMEDIATE CAUSE 420.1			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) Coronary Thrombosis			
DUE TO			
(B) N.B. - Found dead in bed.			
DUE TO			
(C) I saw her the previous day			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. at noon.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from Aug 2, 1955 to Aug 3, 1955 that I last saw the deceased alive on Aug 3, 1955 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
SIGNATURE B. B. Bumbang, M.D.		ADDRESS Elkridge - 27 W. 8/4/53	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF August 5, 1955	
NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS Miss E. R. Williams, Wm. J. Tickner & Sons, Balto. 17, Md	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 8 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

07828

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 191

7320

1. PLACE OF DEATH- COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Ellicott City</u> TOWN <u>Ellicott City</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place)		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> TOWN <u>Ellicott City</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First) <u>LAURA</u> (Middle) <u>DOLORES</u> (Last) <u>WOOD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 21 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>		8. DATE OF BIRTH <u>6-23-1904</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		9. AGE last birthday <u>51</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>George J. Brookheiser</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Kelly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Royden H. Wood, Ellicott City, Md</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of Stomach

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) with metastases

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?					

22. I hereby certify that I attended the deceased from 8-11-41, 19....., to 8-21, 1955, that I last saw the deceasedalive on 8-15-55, 19....., and that death occurred at 5:40 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>		<u>8-24-55</u>		<u>Loudon Park</u>		<u>Baltimore, Md</u>			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
<u>Aug. 22-55</u>		<u>John B. Longheiser</u>		<u>F.C. Higinbotham</u>		<u>Ellicott City, Md</u>			

Ph. B. E. L.

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

AUG 24 1955

BUREAU V. S.